STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: October 2 and 3, 2023 Facility number: 013217 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 11, 2023.	R 0000		
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance (h) The facility must furnish on admission the following: (1) A statement that the resident may file a complaint with the director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility. (2) The most recently known addresses and telephone numbers of the following: (A) The department. (B) The office of the secretary of family and social services. (C) The ombudsman designated by the division of disability, aging, and rehabilitation services. (D) The area agency on aging. (E) The local mental health center. (F) Adult protective services. The addresses and telephone numbers in this subdivision shall be posted in an area			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jamie Langhans	Divisional Director of Health & Wellness	10/24/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	accessible to residents and updated as appropriate. Based on observation, interview and record review, the facility failed to ensure the ombudsman information posted in the facility was up to date with the correct ombudsman and contact information. Finding includes: During a random observation, on 10/3/23 at 9:49 a.m., the Resident Rights poster in the Memory Care unit had not been updated to include the correct ombudsman's name and contact information. During a random observation, on 10/3/23 at 3:32 p.m., the Resident Rights poster in the Assisted Living had not been updated to include the correct ombudsman's name and contact information. An email communication, received from the Ombudsman on 10/4/23 at 4:12 p.m., indicated an email was sent from the Ombudsman to the Executive Director, on 8/10/23, informing the Executive Director, Ombudsman 1 had visited the facility and he was the local ombudsman serving Hamilton County and provided the contact phone number to be posted on the Resident Rights poster. This communication also included the ombudsman's name and contact information. An email communication, received from the Ombudsman on 10/4/23 at 4:12 p.m., indicated an email was sent from the Ombudsman to the Executive Director informing the Executive Director, Ombudsman 1 had visited the facility and the information on the Resident Rights poster was still out of date. Ombudsman 1 provided the	R 0033	**R033 Residents' Rights – Noncompliance** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Correct Ombudsman name and contact information is posted How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken 0 residents were affected by this deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate Executive Director on residents' right to have updated contact information of ombudsman. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Divisional of Operations to confirm ombudsman information is correct on routine visits.	11/24/2023

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	contact phone number to be posted on the Resident Rights poster. This communication also included the ombudsman's name and contact information. During an interview, on 10/3/23 at 3:32 p.m., the Director of Nursing indicated she was not aware of the change in ombudsmen and indicated the Executive Director took care of that information. A current document, titled "RESIDENT BILL OF RIGHTS (IN)," dated as last revised 9-2014 and received from the Corporate Support Nurse on 10/3/23 at 4:46 p.m., indicated "...Facility must furnish on admission the following ...The most recently known addresses and telephone numbers of the following...The ombudsman designated by the division of disability, aging and rehabilitation services...The addresses and telephone numbers in this subdivision shall be posted in and area accessible to residents and updated as appropriate...."			
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be			

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	held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to conduct fire and disaster drills monthly and failed to provide information to show the local fire department had been invited to participate in a fire/disaster drill every six (6) months. Finding includes: During an interview, on 10/3/23 at 1:46 p.m., the Director of Nursing indicated she was not able to find the documentation to show the facility had conducted monthly fire drills. During an interview, on 10/3/23 at 11:30 a.m., the Maintenance Employee indicated he had not conducted a fire drill on any shift since he was hired and indicated he had been hired two (2) months ago. A review of the employee records, conducted on 10//233 and 10/4/23, indicated Maintenance Employee 3 was hired on 7/3/23. A current policy, titled "FIRE DRILL SCHEDULE," dated as last revised 4-2016 and received from the Director of Nursing on 10/3/23 at 2:00 p.m., indicated "...Fire Drills shall be performed MONTHLY. This includes each shift having one drill each quarter...."	R 0092	**R092 Administration and Management - Noncompliance** 0 residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Fire drill completed 10/26/23. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Director or other delegated staff member will be responsible for running an effective fire drill on a monthly basis. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate Director on policy pertaining to Fire Safety and frequency of drills.	11/24/2023

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			How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Divisional of Operations will review Fire Drill records on a monthly basis.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure every shift was covered with staff certified in First Aid and Cardiopulmonary	R 0117	**R117 Personnel - Deficiency** What corrective actions will be	11/24/2023

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	Resuscitation (CPR) for 19 of 42 shifts from 9/25/23 to 10/1/23. Findings include: The schedule of staff on duty, for the period of 9/25/23 to 10/1/23, was reviewed on 10/4/23. The following shifts were found to be without a staff member certified in First Aid, CPR, or both. a. On 9/25/23, there was no staff on duty which had been certified in first aid on the day shift and no staff on duty certified in first aid or CPR on the night shift. b. On 9/26/23, there was no staff on duty certified in first aid or CPR on the night shift. c. On 9/27/23, there was no staff on duty certified in first aid on the evening shift and no staff certified in first aid or CPR on the night shift. d. On 9/28/23, there was no staff on duty certified in first aid or CPR on the night shift. e. On 9/29/23, there was no staff on duty certified in first aid on the day shift and no staff certified in first aid or CPR on the night shift. f. On 9/30/23, there was no staff on duty certified in first aid on the evening shift and no staff certified in first aid or CPR on the night shift. g. On 10/1/23, there was no staff on duty certified in first aid on the evening shift and no staff certified in first aid or CPR on the night shift. During an interview, on 10/3/23 at 3:48 p.m., the Director of Nursing indicated she was not able to locate all the First Aid and CPR certifications for		accomplished for those residents found to have been affected by the deficient practice? No residents were affected by the deficient practice How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Executive Director will complete an audit of all employee files to ensure compliance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Operations will re-educate Executive Director on policy PP-30800 First Aid and CPR. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place Divisional Director of Health & Operations will audit 6 new employee files and on routine visits to ensure compliance	

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	the staff. A current policy, titled "PP-3080-First Aid," dated as last revised 04-2014 and received from the Director of Nursing on 10/3/23 at 4:46 p.m., indicated "...Bickford family members shall be responsible to maintain their certification in CPR and First Aid...."			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to cover equipment which was not in use, failed to label and date food in the refrigerators and freezers to identify the contents and the date opened, failed to have a lid on the trash can when not in use, failed to store freezer items in a manner which kept them from air exposure, failed to label food items with dates received, failed to repair the kitchen cabinet doors and interiors, failed to ensure staff working in the kitchen utilized proper facial hair coverings, failed to ensure cups and scoops were not left in bulk items and failed to store chemicals separate from food items or items used to prepare food. These deficient practices had the potential to affect 39 of 39 residents who received meals from the facility kitchen. Findings include: During an observation of the facility kitchen, on 10/2/23 beginning at 9:40 a.m., with the Dietary Manager in attendance the following observations were made:	R 0273	**R273 Food and Nutritional Services - Deficiency** 0 residents were harmed by this deficient practice. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? An audit of all food storage items was immediately completed on 10/4/23/ and all compromised food was discarded. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken Executive Director will complete dining service quality audit to ensure compliance.	11/24/2023

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	A. 1. In the corner, on the counter, the meat slicer, mixer, and blender were found uncovered. They were not in use. To the left of the uncovered appliances, there was work in progress to hang a microwave on the wall, leaving the uncovered appliances open to debris from the work. 2. In the reach in cooler, where drinks were kept, the following items were found to be undated, unlabeled or both: a. A one gallon container of milk approximately 1/8 full was found without an open date. b. A clear plastic pitcher containing a dark brown liquid was found without a date or a label to identify the substance. c. A clear plastic pitcher containing a red liquid was found without a date or a label to identify the substance. d. A clear plastic pitcher containing an orange liquid was found without a date or a label to identify the substance. e. A clear plastic pitcher containing a dark yellow liquid was found without a date or a label to identify the substance. f. A one half gallon carton of Lactaid milk was found open without an open date. g. A Styrofoam cup with a plastic lid containing a red liquid was found without a date or label to identify the substance. During an interview, on 10/2/23 at 10:01 a.m., the Dietary Manager asked if the items needed to be labeled and dated. 3. A tall rectangular plastic trash can was located next to the metal food preparation table was found to be without a lid. The trash can was not in use. During an interview, on 10/2/23 at 10:08 a.m., the		What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Dining will provide retraining for all cooks, including the Kitchen Manager, and the Maintenance Coordinator to ensure proper food sanitation related to covering equipment not being used, label and date food in the refrigerators and freezers to identify the contents and the date opened, lid on the trash can when not in use, storing freezer items, proper facial hair coverings and chemical storage. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Kitchen Manager/Designee will monitor all food storage areas for proper storage. Executive Director will audit weekly for one month and then monthly for the next three months. This monitoring cycle will start over if improper storage or labeling is found. All staff will be trained on the proper use of hair nets and	

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	Dietary Manager indicated there was no lid for the trash can. 4. In the reach in cooler, a 5.5-liter plastic container with a lid was found without a label to indicated what the contents were. At that time, the Dietary Manager indicated it was pumpkin pie filling. A 32-ounce carton of liquid whole eggs was found open without an open date. The Dietary Manager indicated it was just opened that morning. 5. In the freezer, a long Italian sausage ring, approximately two pounds, was found in plastic left open to air and without a label or date opened. A plastic bag of cookie dough pieces, approximately 40 count was found open to air, without a label or date opened. A plastic bag of frozen biscuits was found in the freezer open to air. At that time, the Dietary Manager indicated they had just used the biscuits for dinner the night prior and asked if they needed to have a label and date. 6. During the observation of the dry storage/pantry, the can goods (vegetables etc.) were found in the can rack without dates they were received. The Dietary Manager indicated the canned goods were used on a first in, first out basis and asked if they needed to be dated with the received date. A 160-ounce bag of elbow macaroni was found on the shelf. The bag was half full and did not have		location. Divisional Director of Operations will monitor compliance on routine site visits and a quality audit will be completed annually.	

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	an open date. The Dietary Manager indicated they just used the product last week. 7. During the observation, it was also noted the kitchen cabinets were in disrepair for 4 cabinets. The cabinet door next to the Lazy Susan cabinet was missing the front door panel, leaving only a frame and the ability to see into the cabinet. To the left of the cabinet and up, there was a piece of the cabinet door missing. To the right, there were two upper cabinets also missing pieces of the doors and the metal handle for the cabinet door under the sink was not attached at the bottom. B. During a second observation of the kitchen, on 10/4/23 beginning at 9:56 a.m., the following observations were noted: 1. The Maintenance Employee was observed working on hanging the microwave. He was in the kitchen wearing a cap but did not have on a facial hair covering net. During an interview, on 10/3/23 at 9:56 a.m., the Maintenance Employee indicated he "probably" should have had one on, he did not know where to find a facial hair net. 2. During an observation, on 10/3/23 at 10:15 a.m., the inside of the lower cabinet under the sink was found to have a sunken base, with a black discoloration and a long wide crack/opening. The sides of the cabinet had discolorations consistent with water damage. The next two (2) lower cabinets to the right of the sink also had sunken bases, black discolorations, and discoloration up the sides. The lower cabinet doors were found to have dried debris speckled across them. During an interview, on 10/3/23 at 10:18 a.m., the			

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	Maintenance Employee indicated he did have wood cut for under the sink and the other cabinets. 3. During the same kitchen observation, on 10/3/23, the door seals on 6 of 8 refrigerator and freezer doors were found broken (slits in the seals) and the freezer door had green tape holding the seal. There was also debris found in the door seals. At that time, the Dietary Manager indicated he was aware of the seal damage and was waiting for repairs to be made. 4. In the bulk item bin, there was a Styrofoam cup found in the cane sugar and a scoop found in the corn meal. 5. In the dry storage/pantry, there was a large container of de-greaser and a half gallon container of bleach stored on the bottom shelf next to the cooking oil. At that time, the Dietary Manager indicated he could store the items in a different area. A current policy, titled "PP-40450-Food Storage-Labeling and Dating," dated as last revised 03-2017 and received from the Director of Nursing on 10/3/23 at 2:50 p.m., indicated "...It is the policy for the Food Service Department to wrap, cover, label, date and store all foods in a safe, appropriate manner...All products are rotated using the first in, first out (FIFO) inventory method...All dates are to be written on the container and represent the date it was opened or prepared...." A current document, titled "Maintenance Coordinator," dated as last revised 08/2016 and received from the Director of Nursing on 10/3/23 at 3:13 p.m., indicated "...The Maintenance			

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	Coordinator position is primarily responsible for ensuring the efficient operation of the Branch by maintaining equipment, building and grounds...Manage supplies and equipment to avoid loss, breakage and waste...Maintenance...Address maintenance issues promptly either by fixing the problem or notifying the Director when outside services are needed...." A current policy, titled "PP-50400-Hazardous Materials," dated as last revised 07-2012 and received from the Director of Nursing on 10/3/23 at 5:14 p.m., indicated "...All hazardous materials shall be properly labeled and stored in a locked storage area...."			
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure an annual health statement was documented in the resident record to indicate the residents were free of contagious disease for 2 of 7 residents reviewed for the annual health statement. (Residents 301 and 401) Findings include: 1. The record for Resident 301 was reviewed on 10/2/23 at 2:51 p.m. Diagnoses included, but were not limited to, end stage renal disease (kidney failure) and dementia without behavioral disturbances.	R 0409	**R409 Infection Control - Noncompliance** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 0 residents were affected by this deficient practice. How the facility will identify other residents having the potential to	11/24/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident 301 admitted to the facility on 9/22/23. There was no annual health statement found in the resident record. 2. The record for Resident 401 was reviewed on 10/3/23 at 4:32 p.m. Diagnoses included, but were not limited to nasal congestion, insomnia, and dementia. Resident 401 admitted to the facility on 5/19/23 and again on 8/10/23. There was no annual health statement found in the resident record. During an interview, on 10/3/23 at 2:52 p.m., the Corporate Support Nurse indicated annual health statements were to be documented on the Medication Administration Record. During an interview, on 10/3/23 at 5:15 p.m., the Corporate Support Nurse indicated she was not able to locate a policy on annual health statements and the facility did follow the state regulations. There was no facility policy provided by the exit date of 10/3/23.		be affected by the same deficient practice and what corrective action will be taken An audit of resident charts was completed on 10/24/23 to ensure compliance. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Health & Operations will provide retraining to the Executive Director and Director of Health & Wellness on requirement for annual health statement that indicates resident is free of contagious disease. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Divisional Director of Health & Operations will audit next 3 new admissions and on routine site visits.	
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/03/2023

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BICKFORD OF CARMEL	5829 EAST 116TH STREET CARMEL, IN 46033

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	treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to ensure an annual tuberculosis skin test or tuberculosis assessment had been completed on 1 of 7 residents reviewed for annual tuberculosis screening. (Residents 201) Findings include: The record for Resident 201 was reviewed on 10/2/23 at 1:50 p.m. Diagnoses included, but were not limited to, hypertension, dizziness, and overactive bladder. The resident admitted to the facility on 8/2/23. There was no current Tuberculosis test or assessment, within the past year, found in the record. During an interview, on 10/3/23 at 2:52 p.m., the Corporate Support Nurse indicated she was not able to locate the annual Tuberculosis test/assessment for the resident. During an interview, on 10/3/23 at 5:15 p.m., the Corporate Support Nurse indicated the facility followed the state regulations. A current policy, titled "PP-72000-Tuberculosis Screening-Resident," dated as last revised 12-2015	R 0412	**R412 Infection Control – Noncompliance** What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? 0 residents were harmed by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken An audit of all resident charts will be completed to ensure compliance What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur. Divisional Director of Health & Operations will provide retraining to the Executive Director and Director of Health & Wellness on tuberculin skin test upon	11/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/03/2023

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	and received from the Director of Nursing on 10/3/23 at 5:14 p.m., indicated "...Upon move-in, all Residents must undergo a two-step Mantoux Purified Protein Derivative (PPD) testing to ensure that they are not infected with tuberculosis, unless the Resident brings proof of a recent negative PPD test, or is a known reactor...."		admission and annual tuberculosis screening. How will the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place. Divisional Director of Health & Operations will audit next 3 new admissions and on routine site visits to ensure compliance.	